

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name : MUHAMMAD IRFAN
 : MUHAMMAD ZAMEER
 Card No : I022-029-119647410-01
 Policy Holder : MUHAMMAD IRFAN
 : MUHAMMAD ZAMEER

Payer Name : TAKAFUL EMARAT

TPA : E CARE - Blue Network

Validity : 19-09-2024 To 18-09-2025

Gender : Male

Date Of Birth : 02-Jul-1988

Patient's Tel No : 0558209860

Service Date:20-Jan-2025

Network : Green

Health Provider :CITICARE MEDICAL CENTER LLC

Direct Access SP - YES

Doctor's Name :SANDIA

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity

Chief Complaints : pc : loose stool vomiting conatining food particles no fever o/e dry oral mucosa Duration:

Vitals:Temp : 36 Bp :128 Pulse :75 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding, Date of Onset : 20/25/2025

Requested Investigations: 0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) Estimated :
 SOLUTION FOR INJECTION,96360, HYDRATION IV INFUSION INIT,0102-152902-1001, LACTATED Cost
 RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF
 INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP,0005-174202-0781, RISEK 40MG-(
 OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,96372, THER/PROPH/DIAG INJ SC/IM,96374,
 THER/PROPH/DIAG INJ IV PUSH

Prescriptions: 0699-200001-1451 - (LOPERAMIDE : 2 MG CAPSULES (HARD GELATIN,0097-708002- Estimated :
 0831 - (TRISODIUM CITRATE DIHYDRATE : 0.58G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CHLORIDE : Cost
 0.52 G) (DEXTROSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION,0240-223401-1171 - (NAPROXEN :
 500 MG TABLETS,0005-150407-1172 - (METOCLOPRAMIDE : 10 MG TABLETS,0248-187801-1171 -
 (DIOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS,

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

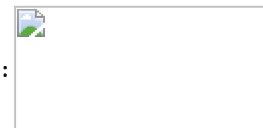
I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : SANDIA

Stamp :



Patient 's signature{Parent : if minor}



Date : Jan- 20- 2025

Signature :

Date : 20-Jan-2025